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The relationship between young adult suicidal behavior and difficulties developing intimacy, problematic family relationships and depression.

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**THE RELATIONSHIP BETWEEN YOUNG ADULT SUICIDAL BEHAVIOR AND
DIFFICULTIES DEVELOPING INTIMACY, PROBLEMATIC FAMILY
RELATIONSHIPS AND DEPRESSION**

By

**Michael E. A. Oosterhoff
B.A. University of Western Ontario 1993, 1996**

**A Thesis
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts at the
University of Windsor**

Windsor, Ontario, Canada

1998

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ABSTRACT

Suicidal Behavior is an increasingly common problem that occurs with young adults. While there has been considerable research in this area there has been little detailed examination of the relationship of suicidal behavior with the salient developmental issues of young adulthood. A primary developmental issue facing young adults is the establishment of intimacy in interpersonal relationships. The establishment of intimacy is necessarily relational in nature and therefore the patterns of intimate relating exposed to while growing up likely have a significant effect the later success in developing intimacy with others. Of the patterns of intimate interpersonal relating exposed to one of the most significant was within the family. If patterns of familial intimacy were dysfunctional then the young adult might encounter difficulty in developing and maintaining intimacy on his or her own. This difficulty, if serious enough, may consequently lead to distress, depression and suicidal ideation and attempt. It was found that young adults reporting suicidal ideation and attempt tended to indicate difficulties with their partners as the primary reason for considering or attempting suicide. In addition young adults reporting significant difficulties in their current relationships also revealed more problematic family functioning. Finally depression and poor family functioning, but not relationship difficulties, were found to be predictive of young adult suicidal behavior.

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CHAPTER I

INTRODUCTION

Within the spectrum of human behavior there are few actions that are as perplexing as suicide. Suicide is a complex and multi-determined phenomenon that has its impetus in diverse and interrelated psychological, social and physiological factors (see Shneidman, 1985, 1996; Kral, 1994; Lester, 1992, 1983; Stillion, McDowell & May, 1989). Psychological theory and research on suicide has developed significantly within the last thirty years and continues to explore the correlates of suicidal behavior (van Egmond & Diekstra, 1990). An area that requires more investigation is young adults, the prevalent types of suicidal behavior they experience and the most relevant correlates of that behavior. Although there has been considerable demographic and epidemiological research on the suicidal behavior of young adults, what is currently lacking is a psychological theory that helps to explain why it occurs. In particular there has been little detailed examination of the relationship between the prevalent types of suicidal behavior and the salient developmental issues of young adulthood. The purpose of this present research is to search for possibly unique developmental and familial factors of young adults that are related to suicidal ideation and attempts. This research is important because it has potentially significant theoretical and practical contributions in terms of explaining the process of suicidal behavior in young adults and augmenting intervention strategies. Following a brief introduction to the demographics of young adult suicide, a theoretical framework will be detailed to elucidate the hypothesized links between the developmental

issues of young adulthood and the prevalent types of suicidal behavior. After this a thorough review of the research literature as it relates to the theoretical framework will be presented.

Demographically the rate of suicidal behavior for young adults represents one of the highest rates across age groups. In the middle 1960's the suicide rate in Canada increased dramatically and reached a plateau that has remained relatively stable over the last 30 years. Suicide in young adults consistently ranges from approximately 15 to 20 per 100 000 (Sakinofsky & Leenaars, 1997; Leenaars, 1994, 1989; Slimak, 1990; Klerman, 1987; McIntosh & Jewell, 1986). In Canada suicide is the second leading cause of death for young people between the ages of 15 to 24 (Canadian Association for Suicide Prevention, 1990). Suicidal ideation and attempts also occur with a high frequency, with approximately 300 to 700 per 100 000 occurring per year (Sakinofsky & Leenaars, 1997, Sakinofsky, 1998)¹. Ideation and attempts are very serious behaviors because they involve a significant degree of distress and are associated with an increased risk of completion (Shneidman 1985, 1994). Wallace (1994) and Rudd (1989) found that nearly 50% of over 700 university students in separate studies had engaged in some suicidal behavior or ideation in the previous year. Between 15 and 28% seriously considered suicide or acted upon these considerations (e.g., came close to making an attempt or told someone they

¹

With these statistics there is the significant problem of under-reporting. This is due in part to variations in reporting criteria (e.g., what constitutes a suicide), absence of official statistical collection, and intentional and unintentional mis-classification. This results in an increased probability of underestimating the rate of suicidal behavior (Rudd 1989; Lester, 1992).

wanted to kill themselves). Finally, slightly more than 5% in both samples attempted suicide. Other studies of young adults have found similar rates of incidence (Wellman & Wellman, 1988; Goldberg, 1981). These figures suggest that suicidal ideation and attempts are prevalent and that serious problems are faced by a relatively large number of young adults. Investigation of this larger and more representative segment of suicidal behavior may provide a comprehensive picture of the process of suicidal behavior in young adults.

THEORETICAL FRAME WORK

A DEVELOPMENTAL PERSPECTIVE

The formation of a useful theoretical understanding of young adult suicide necessarily involves a developmental perspective. This perspective represents an ecological approach in that it attempts to understand the psychology of young adults and their suicidal behavior from the psychosocial context in which they reside. This approach is important to the study of suicide because many decades of developmental theory and research have indicated that as human beings develop over time there are cognitive, emotional, behavioral and physical differences between age groups (Warner-Schaie & Willis, 1991; Whitbourne, 1986; Steinberg & Belsky, 1991; Hethreington & Parke, 1993). These differences have a significant impact on many psychological characteristics and behaviors. Although suicidology has intimated that a developmental perspective is important to understand accurately suicidal behavior in different age groups, it has only

recently begun to investigate the unique developmental issues of young adults. (Leenaars, 1989a; 1989b; 1991; Kaplan & Worth, 1993; Stillion, 1989; Maris, 1981).

YOUNG ADULT DEVELOPMENT: INTIMACY vs ISOLATION

Erikson's (1963) theory of development provides a conceptualization of the primary social and emotional issues facing young adults. Developmentally, young adults (ages 18-25) begin to face some unique psychological and social issues which have their genesis in psycho-developmental needs (as well as socioeconomic and historical circumstance). Psychologically, according to Erikson (1963), the developmental issue or task that primarily faces young adults is the struggle to form intimacy. This involves creating enduring affiliations with friends and especially romantic partners that are mutually intimate, committed and supportive. The development of intimacy represents an essential requirement for optimal psychological adjustment and functioning (Takahashi, 1990; Fassinger & Schlossberg, 1992; Waterman, 1992)². Erikson (1963) indicated that the successful development of intimacy results in a sense of affiliation and love (e.g., connection, satisfaction, and trust). According to Erikson (1963), the unsuccessful establishment of intimacy results in isolation and a difficulty in forming future enduring intimate relationships. Individuals who are unable to establish intimate relationships risk social and emotional isolation along with its associated problems. The problematic

²

This requirement is consonant with Murray's (1938) writing about human needs for affiliation and sex as well as Maslow's (1970) ideas about human needs for belonging and esteem.

development of intimacy can lead to a sense of disconnection, mistrust, dissatisfaction and even self-destructive behavior (e.g., suicidal behavior; Shneidman, 1996). The frustration or absence of intimacy in individuals' lives is known to constitute the impetus for some of the most serious psychological problems (Van Hasselt & Hersen 1994; Sarason & Sarason, 1993).

FAMILY RELATIONSHIPS

The development of intimacy can become problematic for young adults for a number of social and psychological reasons. Although the development of intimacy represents a lifelong dynamic process and is significantly expanded and defined in young adulthood, the rudiments of intimacy have their genesis in childhood and adolescence within a family structure (Whitbourne, 1986; Schaie & Willis, 1991; Steinberg & Belsky, 1991; Violato & Travis, 1995). Since intimacy is necessarily relational in nature, the patterns of relating to which individuals are exposed can have a significant impact on the later development intimacy with others. One of the most salient models of relating that individuals are exposed to involves the patterns of relating in an individual's family. If the familial patterns of relating are problematic, they are potentially psychologically damaging to an individual in that they may inhibit and distort psychological development (such as the ability to form intimate relationships). Problematic family relationships refer to current or antecedent patterns of relating that contain such qualities as emotional enmeshment and disengagement, ineffective communication styles, coercion, conflict, aggression, and the absence of cohesion and psychosocial support (Kaslow, Deering & Racusin, 1994; Wicks-

Nelson & Israel, 1991; Steinberg & Belsky, 1991; Hethreington & Parke, 1993). The presence of these qualities in familial relationships could likely have a deleterious impact on a young adult's successful development of intimacy.

SUICIDAL BEHAVIOR

Suicide is a multi-determined phenomenon with many factors that are important to understanding suicidal ideation, motivation and behavior. In Shneidman's (1985, 1991) comprehensive definition of suicide, he indicates that the common stressor in suicidal behavior is frustrated psychological needs. In essence, Erikson's (1963) conceptualization of the establishment of intimacy as critical to the success of young adulthood represents a psychological need (i.e., something that is necessary for healthy psychological development) that has a heightened significance in young adults. Therefore the frustration of efforts to establish and maintain intimacy for young adults may be connected to prevalent suicidal behavior such as ideation and attempts.

THEORETICAL SUMMARY

Psychologically an important developmental issue that faces young adults is the development of intimacy in interpersonal relationships. This involves the establishment and maintenance of enduring romantic affiliations with partners that are mutually intimate, committed and supportive. The unsuccessful establishment of intimacy involves the risk of social and emotional isolation and its associated problems. The establishment of intimacy is necessarily relational in nature and therefore the patterns of intimate relating exposed to

while growing up likely have a significant impact on the later success in developing intimacy with others. Of the patterns of intimate interpersonal relating exposed to, one of the most significant was within the family. If patterns of familial intimacy were dysfunctional (e.g., contained abuse, were excessively critical) then the young adult might encounter difficulty in developing and maintaining intimacy on his or her own. This difficulty, if serious enough, may consequently lead to distress, depression and suicidal ideation and attempt.

RESEARCH CONCERNING YOUNG ADULT SUICIDAL BEHAVIOR, PROBLEMATIC FAMILY RELATIONSHIPS & DEPRESSION

COMPLETED SUICIDES

Research concerning the development of intimacy with young adults who demonstrate suicidal behavior is scarce. Leenaars's (1988a, 1989a; 1989b) research on completed suicide revealed that the most frequent content in the suicide notes of young adults deals with romantic loss and disappointment. Concerned with applying a life span perspective to completed suicides, Leenaars's (1988a, 1989a; 1989b; 1991) examined the suicide notes of young, middle, and older adults (ages 18-25, 26-55 and 55+ respectively). Leenaars (1989a, 1989b) found that although there were many similarities across age groups, the young adult group was different from the other adult groups in several ways. One of the most important differences in the suicide notes involved prevalent references to

problems in establishing and maintaining interpersonal relationships. Particularly the suicide notes of young adults included descriptions of unbearable interpersonal situations, frustrated attachment or affiliation needs and experiences of intolerable pain from isolation. Two other themes frequently found in young adult suicide notes described an inability to adjust and cope effectively with accrued problems. Leenaars (1989a, 1989b) concluded that the higher frequency of these qualities indicated their increased relevance for the young adult age group. His explanatory model was Erikson's intimacy versus isolation crisis. Other research on this age group has noted the relevance of relationship problems, among others, in completed suicides (e.g., Hawton, Simkin, Fagg & Hawkins, 1995b).

SUICIDAL IDEATION & ATTEMPT

Although the majority of suicidological research has focused on completed suicide over other types of suicidal behavior (Hawton, Haigh, Simkin & Fagg, 1995a), there are some important research studies that investigate the relationship of suicidal ideation and attempts with a variety of psychosocial variables in young adults. Suicidal ideation refers to the cognitive and emotional preoccupation about suicide, suicidal acts, and one's death (e.g., thinking of a way of killings one's self or what it would be like if one were not alive). Suicide attempt refers to the attempt but unsuccessful completion of the ending of one's life. Suicidal ideation and attempts are very prevalent among young adult university students, and the relationship of ideation and attempts to several psychosocial variables is relatively consistent (Rudd, 1989, 1990; Lester, 1990; Hawton, et al. 1995a). These

studies suggest that problematic interpersonal relationships are salient concerns, among others, for young adults who are contemplating and attempting suicide.

Meilman, Pattis & Zeilman (1994) did a one-year prospective study to examine the nature of suicide threats and attempts of university students and the practice of the university counseling center. During 1991, the counseling center staff followed and recorded the presence of demographic and risk factors in sixty undergraduates who were deemed at risk of suicidal behavior. During the year, the counseling center staff recorded eleven suicide attempts and fourteen threats occurring among the client population. Out of fourteen possible issues of concern, the most prevalent were relationship difficulties, work or school failure, recent depression, and social isolation for both threateners and attempters. Specifically, for the students who had threatened suicide, the most prevalent problem was difficulty in a relationship. For those students who had attempted suicide, the most salient issue was academic or occupational failure. For the students that were deemed at risk but exhibited no suicidal behavior during the year, the primary issues of concern were social isolation, followed by depression and relationship difficulties. Meilman, Pattis & Zeilman (1994) caution that these results should be regarded as preliminary findings because of insufficient power for statistical testing due to the small sample size. In sum, this study suggests that the difficulties pertaining to relationships as well as academic and occupational activities are related to threats of suicide and suicidal attempts by students.

Hawton, Haigh, Simkin & Fagg (1995a) investigated the relationship between suicidal attempts of university students and frequent problems which preceded the

attempts. Hawton, et. al. (1995a) examined the files of 119 female and 97 male Oxford university students (aged 18-24) who were admitted to the primary hospital in Oxford because of an attempted suicide during the academic term between 1976 and 1990. There were a total of 254 suicide attempts (104 males/150 females) during this 14 year period because some students made multiple attempts during the academic years. Hawton et. al. (1995a) reported that since 1976 this hospital maintained a protocol for systematically identifying and procuring information on all individuals coming into the hospital who have attempted suicide. These files contained a range of patient characteristics and clinical information which was derived from a detailed psychosocial assessment, case and consultation notes, collateral information (e.g., from partners, other agencies and general practitioners), and standard medical records. The researchers indicated that few of the attempts appeared to be failed suicides and approximately one quarter of the students had or were receiving psychiatric treatment of some kind (particularly common problems were depression and personality disorders). Hawton, et. al. (1995a) reported that the most frequent problems which the students were dealing with at the time of the attempt were interpersonal, particularly difficulties with respect to partners. These difficulties included the breakup of a relationship, the lack of a partner, general dissatisfaction, violence, infidelity, and sexual dysfunction. Other interpersonal difficulties included family problems and specific problems in relationships with others (i.e., conflict, social isolation, emotional difficulties). The second most prominent problem with which students were concerned involved academic difficulties. These included uncertainty about academic and/or career directions, keeping up with studies, performing on examinations, and unhappiness about

being at Oxford.

De-Anda & Smith (1993) investigated the differences among adolescent (aged 12-19), young adult (20-25) and adult (27+) callers of suicide help lines. The sample consisted of 405 (253 females, 157 males) individual callers to two crisis help lines over a two-week period in Los Angeles County. Data concerning age, gender, ethnicity, marital status, the primary reason for calling and contemplating suicide, the degree of suicide risk, and the suicide method were collected. The callers were predominantly troubled by suicidal ideation rather than with an immediate risk for attempting suicide. De Anda & Smith (1993) found the young adult group (35 females, 30 males) reported, in order of significance, depression, love/relational problems and family conflict as the primary reasons for contemplating suicide. These three issues accounted for 63% of the central complaints of young adult callers contemplating suicide. The adolescent group (116 females, 49 males) reported interpersonal problems having to do with love relationships, family conflict, abortion/pregnancy, violence, sexual dysfunction, and relationships with friends as the primary reasons for contemplating suicide and accounted for 65% of the complaints. The adult group (102 females 73 males) reported that depression, alcohol/drugs, and marital/love problems were the primary reasons for contemplating suicide and accounted for 60% of complaints. In general, across the three groups, out of 24 categories for contemplating suicide, the two most frequent reasons for contemplating suicide were depression and a relational/love problem. In terms of young adults, de-Anda & Smith (1993) found that significantly more young adults and adults than adolescents reported loneliness and the absence of a relationship as reasons for suicidal ideation. In

addition, de-Anda & Smith (1993) reported that young adults and adolescents most frequently indicated marital/love problems as the primary reason for contemplating suicide.

FAMILY RELATIONSHIPS

Within the last ten years there has been increasing exploration of the psychosocial factors which underlie and interrelate with suicide. One of the most recent developments has been an increased understanding of the role of family functioning in the etiology of suicidal behavior. Although this research predominantly focuses on adolescents, it is suggestive of a similar kind of relationship for young adults. A review of research on adolescent suicide suggests that, when depression is statistically controlled, the problematic relationships of adolescents with their families is also a significant predictor that leads to a variety of maladaptive coping and self-destructive behaviors including suicide (Lewinsohn, Rohde & Seeley, 1994b; Brent, Perper, Moritz, Liotus, Schweers, Balach & Roth, 1994; Williams & Lyons, 1976). The adolescent research also reveals that problematic family environments often have detrimental effects on the self esteem and interpersonal abilities of adolescents (Sadowski & Kelly 1993; Adams, Overholser & Lehnert, 1994; Spirito, Hart, Overholser & Halverson, 1990)

The patterns of relating in these families of suicidal adolescents are characterized by relationships with parents that are distinctively less cohesive, involving, and supportive, and more conflictual, aversive, and controlling. Specifically, the research findings, derived from both self-report and observational methodologies, indicate that in these families there is lower cohesion and less positive reinforcement for adolescent accomplishments. Parents

use more coercion and do not encourage adolescent input in decision-making. There also tends to be more overt family conflict and more verbal and physical aggression in conflicts. Moreover, there is generally less communication and this communication is not only less effective, but it also tends to contain a negative affective style, a confusing mix of hostility and care, and is generally more critical and intrusive. Finally, the families generally engage in fewer social and recreational activities. The research indicates that these qualities of family relationships are detrimental for adolescents in that they lower adolescents' social competence and self-esteem. It was found that adolescents emerge with a limited repertoire for solving conflict, ineffective communication and problem solving skills, greater enmeshment and/or disengagement with others, greater aversive content and verbal and physical aggression in social interactions, a depressed cognitive style, and more depression (Lewinsohn, Roberts, Seeley, Rohde, Gotlib & Hops, 1994a; Lewinsohn, Rohde & Seeley, 1994b; Adams, Overholser & Spirito 1994; Adams, Overholser & Lehnert, 1994; Brent, Perper, Moritz, Liotus, Schweers, Balach & Roth, 1994; Kienhorst, deWild, Diekstra & Wolters, 1992, 1993; Sadowski & Kelly 1993; Kaslow, Deering & Racusin, 1994; Williams & Lyons, 1976).

When adolescents move into young adulthood it is arguable that the patterns of relating from problematic family relationships of this nature may interfere with their success in establishing intimacy. In other words, the experience with the family may influence the ability of the young adult to negotiate this developmental stage. With young adults there is greater psychological and physical movement away from the family. Although the immediate relational dynamics of the family may become somewhat

antecedent, the patterns of relating with others may remain relatively salient. These dysfunctional schemas of relating would consequently make it difficult for young adults to form intimate relationships successfully. This difficulty could hypothetically result in psychological distress and potentially suicidal behavior. A few research studies investigating suicidal ideation and attempts note the importance of problematic family relationships for young adults although they do not clarify a connection between suicidal behavior and difficulties with intimacy. Rudd (1989, 1990) investigated the prevalence of suicidal ideation in 737 university students and examined the interrelationships among depression, hopelessness, life stress, social support, and suicidal ideation. Rudd (1989, 1990) found that more young adults from disrupted families (i.e., divorce, separation, parent death, remarriage, or never married mother) experienced serious suicidal ideation than those from intact families (biological parents married and living together). In addition, perceived social support from family and friends was negatively correlated with depression, suicidal ideation and hopelessness. Other studies have found that family conflict is related to suicidal behavior. In their examination of the reasons for contemplating suicide of help line callers, de-Anda & Smith (1993) found that for young adults family conflict was the third most common primary reason for contemplating suicide after depression and marital/love problems. With adolescents it was the second reason and with older adults it was the tenth reason. In a detailed investigation of suicide, Goldney (1981) found that depression, hopelessness, the absence of a significant personal relationship and a history of parental conflict were associated with adult women (18-30) who were suicidal.

DEPRESSION

The majority of research indicates that depression is positively related to suicidal ideation, attempts, and problematic family relationships. While there are many significant predictors of suicidal behavior, depression remains one of the most powerful predictors in research (Maris, 1981; Stillion, 1989; Lester 1992). The experience of depression has well known somatic, cognitive, affective, and behavioral dimensions and their severity comprise a barometer of the severity of difficulty and distress. Merikangas, Wicki & Angst (1994) used a prospective design with an epidemiological sample to examine depressive subtypes in a non-clinical sample of 591 young adults over a ten-year period. The researchers classified depression according to duration and episode on a continuum from no depression, single episodes, and recurrent brief episodes, to major depression. Merikangas, Wicki & Angst (1994) found a positive relationship between the severity of depression over the longitudinal course and the severity of young adults' symptomatology, impairment, family history of depression, consequences of depression, and suicide attempts. Merikangas, Wicki & Angst (1994) noted that the most striking finding was the dramatically increased probability of suicide attempts with the increasing severity of depression. Of the 217 young adults who had more than one major depressive episode, recurrent brief depression or both, one third had made at least one attempt and 18% reported a history of suicide attempts.

Goldberg (1981) investigated the factors related to suicidal ideation in a sample of 489 young adults using questionnaires and interviews. Goldberg (1981) found that 51% of the young adults reported at least some suicidal ideation within the month prior to the

interview. Of that group reporting suicidal ideation, over 60% also indicated high levels of depressive symptoms. In addition Goldberg (1981) found that symptoms of depression were strongly related to the presence of suicidal ideation. Only 5% of asymptomatic young adults reported suicidal ideation. These relationships between the severity of depression and suicidal behavior have been consistently found in other research (Maris 1981; Lester, 1990, 1992; deMan, Leduc & Labreche-Gauthier, 1992; Rudd, 1989, 1990). Depression has also been found to be related to problematic family relations and interactions (Keitner, Miller & Ryan, 1996; Kaslow, Deering & Racusin, 1994; Lee & Gotlib, 1994; Coyne, Kahn & Gotlib, 1987). Qualities like low cohesion and support, maltreatment, inappropriate levels of familial control, conflict and ineffective resolution, difficulties with affect regulation and impaired communication patterns are consistently related with depressive symptoms in adolescents.

RATIONALE & HYPOTHESES FOR PROPOSED RESEARCH

The frequency of suicidal behavior, particularly ideation and attempts, is relatively high with young adults (Sakinofsky & Leenaars, 1997; Rudd, 1989; Slimak, 1990; Klerman, 1987; McIntosh & Jewell, 1986). The understanding of suicidal behavior is fundamentally concerned with the social and psychological history leading up to suicidal behavior. There is a growing number of studies that demonstrate important relationships between suicidal behavior and various psychosocial variables (Lester, 1983, 1992; Van Egmond & Diekstra 1990). An area requiring more investigation involves young adults, the prevalent types of suicidal behavior they experience, and the most relevant correlates

of that behavior. In particular there has been little detailed examination of the relationship among the prevalent types of suicidal behavior, the salient developmental issues of young adulthood, and problematic family relationships. The primary developmental issue facing young adults is the establishment of intimacy in interpersonal relationships. Some research, detailed above, suggests that the difficulties in relationships, among other difficulties, are connected with suicidal behavior in young adults. The development of intimacy is relational in nature and in consequence exposure to previous relational patterns could potentially have a significant influence on the later success in establishing intimacy. Arguably one of the most salient models of relating that individuals are exposed to is in the family. If the patterns of familial intimacy were problematic then the young adult might encounter difficulty in establishing intimacy on his or her own. Depending on the seriousness of this difficulty it may lead to distress, depression, and suicidal ideation and attempt. Research described above indicates that problematic family relationships detrimentally affects the interpersonal abilities of adolescents and is a significant predictor in a variety of maladaptive coping behaviors including suicide. The purpose of this research is to investigate whether the suicidal ideation and attempts of young adults are related to difficulties developing intimate interpersonal relationships, problematic relational patterns in the family, and depression.

On the basis of the theory and previous research concerning young adults, it is expected that suicidal ideation and attempt will be related to intimacy difficulties, problematic family functioning and depression. Three specific hypotheses can be made. First, Leenaars' (1989a, 1989b) research on completers and Meilman, Pattis & Zeilman

(1994), Hawton, Haigh, Simkin & Fagg (1995) and de-Anda & Smith's (1993) research on ideation and attempts found that, in general, young adults who engage in suicidal behavior frequently indicate having problems in interpersonal relationships. This evidence suggests that this problem may be indicative of difficulties in establishing and maintaining intimate romantic relationships. On the basis of this evidence it is hypothesized that, since the development of intimacy is important for young adults, difficulty in intimate relationships will be related to suicidal ideation and attempts.

Second, Adams, Overholser & Lehnert (1994), Brent et. al. (1994), Lewinsohn, et. al. (1994a, 1994b) and others' research on the relationship of family relations and suicide in adolescents indicates that family disruption and conflict is an important mediator in interpersonal development. The presence of family conflict suggests greater relational problems within the family and may have a lasting impact on family members. In particular, this adolescent research suggests that environments with problematic family relations often have detrimental effects on adolescents' interpersonal abilities (e.g., limited repertoire for solving conflict, ineffective communication and problem solving skills, greater enmeshment and/or disengagement with others, greater aversive content, and verbal and physical aggression in social interactions). With respect to these findings it is hypothesized that problematic family relationships will be related to young adults' difficulties in intimate relationships.

Third, it is hypothesized that difficulty in intimate relationships, problematic family relationships, and depression will be related and will contribute to the prediction of suicidal behavior in young adults. This is based on Meilman, Pattis & Zeilman (1994),

Hawton, Haigh, Simkin & Fagg (1995) and de-Anda & Smith's (1993) findings which reveal a high frequency of reported relationship difficulties in young adults exhibiting suicidal behavior. This is also supported by Adams, Overholser & Lehnert (1994), Brent et. al. (1994) and Lewinsohn's, et. al. (1994b) research on adolescents which indicates that family disruption and conflict are related to suicidal behavior. Finally this hypothesis is based on the findings of Merikangas, Wicki & Angst (1994), Goldberg (1981) and numerous others who report the relationship of depression to the suicidal behavior of young adults.

CHAPTER II

M E T H O D

PARTICIPANTS

Three hundred and sixty one university students from first through fourth year participated in the study for course credit. In terms of gender, approximately one third, 121 (33.5%), of the participants were male and approximately two thirds, 240 (66.5%), were female. The age of the participants ranged from 18-25 with a mean age of 20.57 ($SD = 1.71$).

MEASURES

1. Depression

Depression was measured by the Center for Epidemiological Studies -Depressed Mood Scale (CES-D) (Radloff, 1977; Corcoran & Fisher, 1987) (see Appendix A). The CES-D is a 20 item self-report scale which is designed to measure the current level of depressive symptomatology (particularly depressed mood) in the general population in the previous two weeks. The identical questions were repeated for symptoms over the previous year to provide a longer time frame. Psychometrically the CES-D is a reliable and valid instrument. In terms of reliability, the CES-D reports good internal consistency ($\alpha =$

.85 for the general population; Split Half/Spearman-Brown .77-.92) and fair but acceptable temporal stability (test retest correlations .67 over two to eight weeks). In terms of validity, the CES-D reports excellent concurrent validity and correlates significantly with other depression scales (i.e., Beck Depression Inventory). The CES-D has been shown to discriminate between the general population and patient groups in terms of severity of depression (Corcoran & Fisher, 1987).

2. Suicide

Suicide ideation and attempts were measured by the Harkavy Asnis Suicide Survey (HASS) (Friedman & Asnis, 1989) (see Appendix B). This three-part instrument is designed to gather a range of information about suicidal ideation and attempt including type, frequency and motivation. The first and second parts consist of 21 identical questions assessing the frequency of a range of suicidal behavior and motivation within the past two weeks and the lifetime of an individual. Two questions were added to these two parts. First, a question concerning the individual's intent to die when attempting suicide was included because this aspect of suicidal behavior was not directly represented in this section of the HASS (Item 22). Second, a question was included to ascertain the frequency of suicidal behavior under the influence of alcohol (Item 23) since the frequency is known to be high and the original questions concerning substance usage are general.

The third part consists of 8 subdivided questions that measure an individual's experiences with suicidal behavior (e.g., suicidal thoughts, plans and attempts, motivations, method, treatment, knowledge of others' suicidal behavior). Two questions

were added to this section. The first concerned the number of attempts since eighteen years of age given the emphasis of this present research on the young adult years. Second, a question concerning an individual's reasons for thinking about suicide was added and was identical to that concerning suicide attempts. Six alternative reasons were included to both of these questions with instructions to rank them from most to least serious if more than one reason applied.

In term of reliability the HASS has good internal consistency (α = range .907-.924) for clinical and non-clinical samples. Consistent with research on the relationships between suicidal behavior and various psychological factors, the HASS is moderately positively related to measures of depression, negative life stress, impulsiveness, and aggression. The HASS is also not related to social desirability and positive life stress.

3. Intimacy

Intimacy was measured by the Index of Marital Satisfaction (IMS) (Corcoran & Fisher, 1987) (see Appendix C). The IMS is a 25-item scale that was designed to measure the severity of difficulties that one partner has in a relationship. This instrument was used as an indicator of intimacy success because the items concern the general components of intimacy (e.g., communication, trust, connection) and consequently relationship satisfaction should reflect intimacy satisfaction (and therefore success). A clinical cutoff score is reported which identifies respondents with clinically significant relational problems (≥ 30). One item was eliminated because it was not relevant to the age group under study (Item 17: "We do a good job managing our finances"). This was replaced with one item

specifically about communication (Item 25: “I feel that I can discuss anything with my partner”). The “marital” references in the instructions were changed to reflect a romantic relationship with a significant partner. It was also added in the instructions that those not in a current romantic relationship were to indicate and rate their relationship satisfaction with a close friend.

Psychometrically the IMS has good reliability and validity. The instrument reports good internal consistency ($\alpha = .96$). The IMS also reports acceptable construct validity in that it has been found to correlate with indexes of sexual satisfaction and marital problems and not with measures that have nothing to do with marital problems. The IMS also indicates excellent concurrent validity in that it has been found to correlate with Locke-Wallace Marital Adjustment Test. Finally the IMS had been shown to discriminate between couples with no relationship problems and those with known relationship problems using the clinical cutoff score (Corcoran & Fisher, 1987).

4. Family Functioning

Family functioning was measured by the Family Assessment Device (FAD) (Epstein, Lawrence & Bishop, 1983) (see Appendix D). The FAD is a 60-item instrument which covers seven dimensions of family functioning: general functioning, problem solving, affective responsiveness, affective involvement, communication, roles, and behavioral control. These dimensions tap the problematic areas in families that are consistently identified in previous research. Problem Solving concerns the capacity of the family to resolve problems in ways that maintain effective family functioning and integrity.

Affective Responsiveness is concerned with family members' experience of appropriate affect with a range of stimuli and emphasizes welfare and emergency emotions. Affective Involvement deals with the degree to which family members are interested in and value other members concerns and activities. Communication deals with the clarity and directness in the exchange of information among family members. Roles focuses on the established patterns for handling family functions like the provision of nurturance, support and resources and the equitableness and appropriateness of those patterns. Behavioral Control measures the patterns of control in different situations (e.g., social, dangerous) and the way the family maintains and expresses behavioral standards. General functioning is a synthesis of these six dimensions. Item 27 was changed from "We have no clear expectations about toilet habits" to "We have no clear expectations about appropriate family behavior" since the original was not relevant to the age group under study.

In terms of reliability the FAD reports good internal consistency across the whole measure ($\alpha = .96$; $\alpha = .70-.78$ across the six dimensions except for the roles scale which reported an $\alpha = .57-.69$). The test-retest reliability over a one-week interval was found adequate ($\alpha = .66-.76$ across the dimensions). The FAD reported adequate construct validity and was highly correlated with other family functioning measures (FACES II, FES) indicating good concurrent validity. The FAD also demonstrated decent discriminant validity by significantly distinguishing individuals from clinical and non-clinical families. The FAD also demonstrated some predictive validity in that the measures of family functioning were related to stroke recovery, major depression recovery, substance abuse, and post-divorce adjustment (Corcoran & Fisher, 1987; Swain & Harrigan 1995).

PROCEDURE

Upon entering the classroom respondents were provided with the consent form (Appendix F) that briefly outlined the nature of the study and their voluntary confidential participation. After the experimenter verified that the respondents understood the consent form, answered any questions and the respondent consented to participate, each respondent was provided with the series of questionnaires. The package began with demographic information (Appendix E) and was followed with the questionnaire on depression (CES-D), relationship satisfaction (IMS), family relationship (FAD) and finally suicide (HASS). Before the participant began filling out the questionnaires, the investigator asked each respondent to fill out the questionnaires as completely as possible, indicated to them that there were no right or wrong answers, and that they could freely voice any questions or concerns. Upon completion of the questionnaires the participants were provided with a debriefing form (Appendix G) that detailed the nature of the study and included the phone numbers of three local intervention agencies.

CHAPTER III

R E S U L T S

The statistical analysis was completed using SPSS v.6 for Windows. First a brief presentation of the demographic information regarding young adults suicidal behavior will be made. Following this an examination of the normality data and the reliability analysis will be made. Then the Pearson correlations among the measures and their analysis will be examined. Finally the results regarding each of the three specific hypotheses will be presented.

Demographics

There was a total of 361 participants with 121 (33.5%) males and 240 (66.5%) females. Of 361 students, 205 (57%) reported suicidal thoughts occurring across an age range of 8 to 24 years. Of these respondents reporting suicidal thoughts approximately equal numbers of males and females reported suicidal ideation. Proportionally 67 of a total of 121 (55%) male respondents and 138 of a total of 240 (57%) female respondents reported suicidal thoughts. Of that sample reporting suicidal thoughts, 84 students reported suicidal ideation between the ages of 18 to 24 years. This young adult sample represented 23% of the 361 participants and 41% of the 205 reporting suicidal thoughts. Proportionally this young adult sample reporting suicidal thoughts was composed of

approximately equal numbers of men and women, with 33 of 121 (27%) males and 51 of 240 (21%) females. Of the young adults reporting suicidal thoughts, 21 (25%) indicated serious suicidal ideation in that they reported that the thoughts had persisted for at least seven days and/or they had a plan.

From 361 students, 36 (10%) students reported attempted suicide within an age range of 10 to 20 years. Of suicide attempts, proportionally 4 (3%) were male and 32 (13%) were female. Eleven students reported attempting suicide between the ages of 18 to 24. This young adult sample of attempters represents 31% of the total reported suicide attempts and 3% of 361 participants. In terms of the proportional gender make up of this sample, 2 were male and 9 were female. This represents 2% of the 121 male participants and 4% of the 240 female participants. Of young adult attempters, 8 (88%) indicated serious suicidal attempts in that they reported they required medical attention and/or wanted to die when they attempted.

Normality & Reliability Analysis

Depression over the week (CES-D(W)) and year (CES-D(Y)) and family functioning (FAD) appeared to be adequately normally distributed with low skewness and kurtosis. It was expected that the measure of suicidal behavior over the lifetime (HASS(L)) and the last two weeks (HASS(W)) would be mildly to strongly positively skewed (Skewedness = 1.11 and 3.43 respectively) and have a slight to strongly peaked distribution (Kurtosis = .563 and 15.94 respectively) given the relatively low frequency of the behavior. Unexpectedly, it was found that the relationship satisfaction measure (IMS)

was significantly positively skewed (Skewedness = 1.33; $Z=10.23$ $p<.001$) but had an adequate kurtosis. This indicated that the variability in the measure of relationship satisfaction was relatively low. This truncated variability was created by participants indicating a high degree of relationship satisfaction. The mean responses ranged from approximately one to two on a seven point scale for each of the 25 items. These means correspond to responses of “most” or “all of the time” for positive relationship items (e.g., my partner is affectionate enough) and “very rarely” or “none of the time” for negative relationship items (e.g., my partner really does not understand me). The implications of the low variability of the IMS measure will be discussed in detail further on.

The distributions of the relationship and suicide scales generated some concern and were inspected more closely. Logarithmic and Square Root transformations were attempted on these variables but they were found not to improve the distributions or demonstrated inconsistent results when employed in subsequent analyses. Given these findings and the fact that transformations make interpretation of results very difficult it was decided to retain the untransformed variables in the analysis. The use of a large sample size (>200) with established measures should mitigate some of the impact of skewness and kurtosis (e.g., the underestimate of variance) (Tabachnic & Fidell, 1996). In addition it should be noted that these distributions do not appear due to problems in the measure but are empirical distributions reflecting the nature of the phenomenon under study. It has been generally recommended that if a variable is not normally distributed and the distribution is not attributable to the measure itself then the data should be allowed to

reflect this fact (Diekhoff, 1992). The distribution of these phenomena and their implications on the findings will be discussed in greater detail in the discussion.

An analysis of the internal consistency of the four measures was conducted prior to further analysis to assess their reliability. The results can be seen in Table 1 and Table 2. All of the measures reported high alphas indicating good internal consistency and acceptable reliability. Most of the seven FAD sub-scales also reported acceptable reliability but individually none exceeded the reliability of the scale as a whole.

Correlation Analysis

Table 3 contains the correlations among the variables and reveals many significant and substantial (i.e., $r \geq .2$; Jaccard & Becker 1997; Diekhoff 1992) positive correlations between students' self-reported ratings on depression (CES-D), family functioning (FAD), suicidal behavior (HASS) and relationship satisfaction (IMS). Suicidal behavior over the last two weeks (HASS(W)) was significantly related to depression over the week (CES-D(W) $r = .5844, p < .001$), depression over the last year (CES-D(Y) $r = .4337, p < .001$), and family functioning (FAD, $r = .2254, p < .001$) but not with relationship dissatisfaction (IMS, $r = .0968, p > .05$). Suicidal behavior over the lifetime (HASS(L)) was significantly related to depression over the week (CES-D(W) $r = .4426, p < .001$), depression over the last year (CES-D(Y) $r = .4984, p < .001$), and family functioning (FAD, $r = .3335, p < .001$) but again not with relationship satisfaction (IMS, $r = .0582, p > .05$). In terms of suicide these correlations indicate that increasing suicidal behavior is associated with greater depression and increasingly problematic family relationships but not with relationship

dissatisfaction. Relationship satisfaction was significantly related to depression over the week (CES-D(W) $r = .2075, p < .001$), and depression over the year (CES-D(Y) $r = .1852, p < .001$) and marginally (i.e., $r < .2$) to family functioning (FAD, $r = .1462, p < .01$). These correlations suggest that increasing relationship dissatisfaction is related to greater depression, particularly over the past week, and to some degree increasingly problematic family functioning. Family functioning was also significantly related to depression over the week (CES-D(W) $r = .2160, p < .001$), and depression over the last year (CES-D(Y) $r = .3547, p < .001$) which suggests that increasingly problematic family functioning is related to greater depression. While the majority of the correlations were significant, curiously the correlations between relationship satisfaction (IMS) and several variables, particularly suicide, revealed marginal (i.e., $r < .2$) or non-significant correlations. This may be due to the lack of variability in the responses in the relationship satisfaction measure.

Table 4 contains the correlations among the FAD subscales and the measures. The majority of the subscales correlate significantly with the measures of depression, suicide, and relationship satisfaction although their strength varies. General Functioning, as a synthesis of the six dimensions, was significantly and substantially correlated with all the variables and only marginally (i.e., $r < .2$) to relationship satisfaction. Problem solving was significantly correlated with depression, suicide, and relationship satisfaction but was only substantially (i.e., $r \geq .2$) correlated with depression over the year (CES-D(Y)) and suicidal behavior over the lifetime (HASS(L)). Similar patterns were observed for Communication, Affective Responsiveness, and Affective Involvement. This pattern may reflect the longitudinal nature in that increasing problems in Problem Solving,

Communication, Affective Responsiveness, and Affective Involvement in the family is related to an increasing occurrence of depression and suicidal behavior in the long term as a young adult.

To assess difference between the magnitudes of some of the correlations between the measures Fisher's R to Z test was employed. The correlations that were examined were those containing one variable significantly related to another variable twice with different time frames (e.g., family functioning correlated with depression over the last week and year). Five comparisons were made and two were found to be significant (Table 5). It was found that the correlation between depression over the week and suicidal behavior over the past two weeks was significantly greater than the correlation of depression over the week with suicidal behavior over the a lifetime ($Z = 2.57, p < .05$). This indicated that more recent suicidal behavior is connected with more recent and greater symptoms of depression. This was not the case for depression over the year and suicide ($Z = 1.10, p > .05$). This suggests that a depression with a lengthier time span has a strong but relatively equal association with suicidal behavior both in the short term and the long term. The correlation of family functioning with depression over the year was also found to be significantly greater than the correlation of family functioning with depression over the week ($Z = 1.98, p < .05$). This suggests that lengthier depression as a young adult is associated with increasingly problematic family functioning. The patterns of the correlations between the FAD subscales and depression suggest that Problem Solving, Communication, Affective Responsiveness and Affective Involvement are important contributors to this relationship. The last two comparisons between family functioning and

suicidal behavior over the last two weeks and life time ($Z = 1.53, p > .05$), and relationship satisfaction and depression over the week and year ($Z = .30, p > .05$) proved not to be significantly different. This finding does not mitigate the initial correlations which suggest that family functioning and depression during the past week are significantly and substantially related to suicidal behavior and relationship satisfaction respectively.

Table 1

Reliability Results for the Measures of Depression, Suicide , Family Functioning, Relationship Satisfaction.

Measure	Mean	Standard Dev	Alpha
CES-D(W)	15.26	10.36	.9103
CES-D(Y)	17.78	10.33	.9184
HASS(W)	7.68	8.62	.8815
HASS(L)	23.88	17.47	.9220
FAD	129.53	24.54	.9476
IMS	25.66	22.04	.9468

Note:

CES-D(W) = Depression over the past week (W).

CES-D(Y) = Depression over the past year (Y).

HASS(W) = Suicidal behavior over the past 2 weeks (W).

HASS(L) = Suicidal behavior over the lifetime (L).

FAD = Family Functioning.

IMS = Relationship Satisfaction.

Table 2

Reliability Results for the FAD Subscales.

Measure	Mean	Standard Dev	Alpha
(FAD SUB-SCALES)			
General Functioning	23.93	7.03	.9007
Problem Solving	13.57	3.38	.8110
Communication	17.56	4.05	.7764
Roles	24.01	4.22	.6685
Affective Responsiveness	16.60	4.81	.8748
Affective Involvement	14.98	3.64	.7371
Behavioral Control	18.70	3.51	.5813

Table 3

Correlations Between Measures of Depression, Suicide, Family Functioning and Relationship Satisfaction.

	CES-D(Y)	HASS(W)	HASS(L)	FAD	IMS
CES-D(W)	.5807***	.5844***	.4426***	.2160***	.2075***
CES-D(Y)		.4337***	.4984***	.3547***	.1852***
HASS (W)			.5308***	.2254***	.0968 ns
HASS (L)				.3335***	.0582 ns
FAD					.1462**

* $p < .05$, ** $p < .01$ *** $p < .001$

Note:

CES-D(W) = Depression over the past week (W).

CES-D(Y) = Depression over the past year (Y).

HASS(W) = Suicidal behavior over the past 2 weeks (W).

HASS(L) = Suicidal behavior over the lifetime (L).

FAD = Family functioning.

IMS = Relationship satisfaction.

Table 4.

Correlation Between FAD Subscales and Measures.

	CES-D(W)	CES-D(Y)	HASS(W)	HASS(L)	IMS
General Functioning	.2078***	.3796***	.2075***	.3799***	.1107*
Problem Solving	.1662**	.3155***	.1885***	.3212***	.1279*
Communication	.1321*	.2575***	.1777**	.3204***	.0534 ns
Roles	.2326***	.2538***	.2334***	.2051***	.1444 **
Affective Responsiveness	.0890 ns	.2544***	.1501**	.2274***	.1505 **
Affective Involvement	.1828**	.2782***	.1575**	.2390***	.0697 ns
Behavioral Control	.1621**	.1855***	.1287*	.1464**	.1261*

* $p < .05$, ** $p < .01$ *** $p < .001$ Note:

CES-D(W) = Depression over the past week (W).

CES-D(Y) = Depression over the past year (Y).

HASS(W) = Suicidal behavior over the past 2 weeks (W).

HASS(L) = Suicidal behavior over the lifetime (L).

FAD = Family Functioning.

IMS = Relationship Satisfaction.

Table 5. Comparison of Correlations for Depression, Family Functioning, Relationship Satisfaction and Suicide.

Comparison	Correlations		Z Score
Comparison 1	HASS (W)	HASS(L)	
CES-D (W)	.5844	.4426	2.57 $p < .05$
Comparison 2	HASS (W)	HASS(L)	
CES-D (Y)	.4337	.4984	1.10 $p > .05$
Comparison 3	CES-D(W)	CES-D(L)	
FAD	.2094	.3697	1.98 $p < .05$
Comparison 4	HASS(W)	HASS(L)	
FAD	.2254	.3335	1.53 $p > .05$
Comparison 5	CES-D(W)	CES-D(L)	
IMS	.2075	.1852	0.30 $p > .05$

Note:

CES-D(W) = Depression over the past week (W).

CES-D(Y) = Depression over the past year (Y).

HASS(W) = Suicidal behavior over the past 2 weeks (W).

HASS(L) = Suicidal behavior over the lifetime (L).

FAD = Family Functioning.

IMS = Relationship Satisfaction.

Hypothesis One: Difficulty Developing Intimacy & Suicidal Ideation and Attempt

To analyze the relationship of difficulty developing intimacy with suicidal ideation, a comparison between the difference in average age of respondents that indicated girl/boyfriend difficulties ($M = 18.00$, $SD = 2.56$) or family difficulties ($M = 15.74$, $SD = 2.50$) as the primary reason for contemplating suicide was done using an independent groups T-test. A significant difference was found $t(127) = 2.25$, $p < .001$, indicating that the age at which respondents reported girl/boyfriend difficulties was older (i.e., a young adult) than the age at which respondents reported family difficulties as the primary reason for thinking about suicide. Although there were no specific hypotheses, a follow-up analysis using a oneway ANOVA with a Tukey HSD test was used to investigate any other differences in age across primary reason for thinking about suicide. This test was significant $F(2, 200) = 5.94$, $p < .001$ and the Tukey HSD test indicated that for the other possible primary reasons for thinking about suicide (academic, friend or work difficulties) there was no significant difference in age.

To investigate the same relationship with suicide attempts a similar procedure of analysis was done. Using an independent groups T-test a planned comparison between the difference in age of respondents that indicated girl/boyfriend difficulties ($M = 17.58$, $SD = 2.87$) or family difficulties ($M = 14.90$, $SD = 2.56$) as the primary reason for attempting suicide was done. A significant difference was found $t(31) = 2.67$, $p < .05$, indicating that the age at which respondents reported girl/boyfriend difficulties was older than the age at which respondents reported family difficulties as the primary reason for attempting suicide. These findings are in contrast to the absence of a significant correlation between suicidal

behavior (HASS(W), HASS(L) scores and relationship satisfaction ratings (IMS scores) . A follow-up analysis using a oneway ANOVA with a Tukey HSD test was used to investigate any other differences in age across primary reason for thinking about suicide. This test was significant $F(4, 36) = 2.97, p < .05$, but none of differences with the Tukey's were significant at the .05 level. This Tukey finding may be due to the fact that the number of adult attempts is relatively small and the Tukeys is a conservative procedure and together they may diminish the likelihood of significant findings.

Hypothesis Two: Familial Functioning & Intimate Relationships

Investigation of the relationship of problematic family relationships with young adults' difficulties in intimate relationships was done using an independent groups T-test to compare the rating of family functioning (FAD score) between respondents with a bifurcated rating of relationship satisfaction (IMS score). These two groups were formed based on the clinical cutoff score reported in the IMS's psychometric information which identified respondents with clinically significant relational problems (IMS scores ≥ 30 ; FAD scores, $M = 133.97, SD = 23.34$) and those that did not (IMS scores ≤ 29 ; FAD scores, $M = 127.84, SD = 24.96$). A significant difference was found $t(337) = 2.851, p < .05$, indicating that the reported family functioning is more problematic for those respondents with significant relationship problems (scores ≥ 30) than with those who do not. This finding is supported somewhat by the presence of a small but significant correlation ($r = .1462, p < .01$) between family functioning ratings (FAD scores) and relationship ratings (IMS scores). In particular, in terms of the FAD subscales (Table 4), it

appeared that Problem Solving ($r = .1279, p < .05$), Roles ($r = .1444, p < .01$), Affective Responsiveness ($r = .1505, p < .01$), Behavioral Control ($r = .1261, p < .05$) and General Functioning ($r = .1107, p < .05$) were significantly but marginally ($p < .2$) related to relationship satisfaction ratings. Communication ($r = .0534, p > .05$) and Affective Involvement ($r = .0697, p > .05$) were not significantly related to relationship satisfaction ratings. T-tests were done to examine whether there was a difference in FAD subscales in regards to the divided relationship satisfaction scores. It was found (Table 6) there was a significant difference for Problem Solving, Affective Responsiveness, and Roles but not for Communication, Affective Involvement, Behavioral Control, and General Functioning. These findings indicate that young adults with relationship satisfaction scores greater than 30 (reflecting dissatisfaction) report significantly higher family problems in the dimensions of Problem Solving, Affective Responsiveness, and Roles.

Table 6.

T-Tests for Subscales of Family Functioning With Relationship Satisfaction

Variable	Mean & Standard Deviation	Test
Problem Solving		
IMS \geq 30	$M = 14.16, SD = 3.00$	$t(346) = 2.18,$
IMS \leq 29	$M = 13.32, SD = 3.50$	$p < .05$
Affective Responsiveness		
IMS \geq 30	$M = 17.54, SD = 4.64$	$t(349) = 2.50,$
IMS \leq 29	$M = 16.18, SD = 4.76$	$p < .05$
Roles		
IMS \geq 30	$M = 24.81, SD = 4.41$	$t(344) = 2.34,$
IMS \leq 29	$M = 23.68, SD = 4.11$	$p < .05$
Communication		
IMS \geq 30	$M = 17.73, SD = 3.72$	$t(348) = 0.50,$
IMS \leq 29	$M = 17.50, SD = 4.24$	$p > .05$
Affective Involvement,		
IMS \geq 30	$M = 15.45, SD = 3.34$	$t(348) = 1.58,$
IMS \leq 29	$M = 14.79, SD = 3.80$	$p > .05$
Behavioral Control		
IMS \geq 30	$M = 19.22, SD = 3.61$	$t(345) = 1.78,$
IMS \leq 29	$M = 18.49, SD = 3.46$	$p > .05$
General Functioning		
IMS \geq 30	$M = 24.86, SD = 6.51$	$t(348) = 2.53,$
IMS \leq 29	$M = 23.62, SD = 7.31$	$p > .05$

Hypothesis Three: Family Functioning, Relationship Satisfaction, Depression and Suicidal Behavior

The contribution of relationship satisfaction, family functioning and depression to suicidal behavior was examined using a multiple regression analysis. The direct method was employed to examine the relationship between this set of predictor variables and the criterion variable, suicidal behavior. This method was used because it was important theoretically to include all of the relevant predictor variables to quantify their relationship with the criterion variable (Tabachnick & Fidell 1996; Dieckoff, 1992). First it was investigated how current depression (CES-D(W), $M=15.40$, $SD=10.58$), relationship satisfaction (IMS, $M=25.66$, $SD=21.73$), and family functioning (FAD, $M=129.89$, $SD=24.60$) predicted current suicidal behavior (HASS(W), $M=4.68$, $SD=7.94$). Examining the correlations in Table 7, all three predictors were significantly correlated with suicidal behavior. Table 8 displays the unstandardized regression coefficients, their standard error, the standardized regression coefficients, the multiple R^2 and the adjusted R^2 , the T-test, and level of significance. This table also includes the multiple R, its standard error, R^2 and the adjusted R^2 . The multiple correlation indicated an $R = .60$ ($R^2 = .37$) and was found to be significant, $F(3, 333) = 65.54$, $p < .0001$. This suggests that the significant predictors accounted for 37% of the variance in predicting suicidal behavior over the last two weeks. In terms of the regression two variables, depression (CES-D(W) ($t = 12.97$, $p < .0001$) and family functioning ($t = 2.24$, $p < .05$) contributed significantly to the prediction of suicidal behavior within the past two weeks. Intimacy satisfaction (IMS) was not found to be significant ($t = -1.050$, $p > .05$). The non-significance of relationship satisfaction toward the

prediction of suicide is likely related to the low variability of the IMS measure.

In a second analysis the contributions of the same variables to suicidal behavior over a lifetime (HASS(L) $M=15.58$, $SD=15.18$) was examined. The depression variable with the year time frame (CES-D(Y) $M=17.81$, $SD=10.44$) was also employed. The correlations (Table 9) indicated only two variables, family functioning (FAD) and depression over the past year (CES-D(Y)) were significantly correlated with suicidal behavior over the lifetime. Relationship satisfaction (IMS) was not significantly correlated with suicidal behavior over the lifetime (HASS(L)). Table 10 displays the unstandardized regression coefficients, their standard error, the standardized regression coefficients, the T-test and level of significance. This table also includes the multiple R, its standard error, R^2 and the adjusted R^2 . The multiple correlation demonstrated an $R=.53$ ($R^2=.28$) and was significant, $F(3, 332) = 44.30$, $p < .0001$. This indicated that the significant variables accounted for 28% of the variance in predicting suicidal behavior over the life time. The regression indicated that two variables depression (CES-D(Y), $t = 8.80$, $p < .0001$) and family functioning (FAD, $t = 3.83$, $p < .001$) contributed significantly to the prediction of suicidal behavior occurring within a lifetime. Again intimacy satisfaction (IMS) were found not to be significant ($t = -1.050$, $p > .05$).

Table 7

Regression Correlations for Depression Over A Week, Family Functioning, Relationship Satisfaction and Suicidal Behavior Over The Past Two Weeks.

	CES-D(W)	FAD	IMS
HASS(W)	.600***	.223***	.092*
CES-D(W)		.221***	.212***
FAD			.147**

* $p < .05$, ** $p < .01$ *** $p < .001$

Table 8

Multiple Regression for Suicidal Behavior Over The Past Two Weeks with Depression Over A Week, Family Functioning and Relationship Satisfaction.

Variable	B	SE B	Beta	T	Sig T
CES-D(W)	.4414	.0340	.5881	12.971	.0000
FAD	.0325	.0144	.1005	2.245	.0254
IMS	-.0171	.0163	-.0469	-1.050	.2946
(Constant)	-5.893	1.862		-3.164	.0017
Multiple R	.6093				
R Square	.3712				
Adjusted R Square	.3655				
Standard Error	6.330				

Table 9

Regression Correlations for Depression Over A Year, Family Functioning, Relationship Satisfaction and Suicidal Behavior Over The Lifetime.

	CES-D(Y)	FAD	IMS
HASS(L)	.504***	.345***	.069 ns
CES-D(Y)		.361***	.184***
FAD			.153**

* $p < .05$, ** $p < .01$ *** $p < .001$

Table 10

Multiple Regression for Suicidal Behavior Over The Lifetime with Depression Over A Year, Family Functioning and Relationship Satisfaction.

Variable	B	SE B	Beta	T	Sig T
CES-D(Y)	.6431	.0730	.4420	12.971	.0000
FAD	.1179	.0307	.1916	2.245	.0001
IMS	-.0294	.0338	-.0413	-1.050	.3841
(Constant)	-10.44	3.790		-3.164	.0017
Multiple R	.5346				
R Square	.2859				
Adjusted R Square	.2794				
Standard Error	12.89				

CHAPTER IV

DISCUSSION

The purpose of this research was to investigate the developmental and familial factors of young adults which are related to suicidal ideation and attempts. In general this investigation found these factors to be related to suicidal behavior. To evaluate the findings, each of the factors will be examined in turn. First the influence of the relationship satisfaction measure and its skewed nature on the results will be evaluated. The findings of the correlations among the measures and their analysis will then be reviewed to examine the interrelationships among the variables and the information they provide. Following this, the findings of three hypotheses will be examined in detail. Finally, a brief review of the important findings, the general limitations of this study, possibilities for research to follow up on these findings and the clinical relevance of the findings will be presented.

Relationship Satisfaction Measure

While the distributions of many of the variables were expected, the significantly truncated variability of the relationship satisfaction measure (IMS) was unexpected. This low variability, created by participants indicating a high degree of relationship satisfaction, is informative of young adults in and of itself. That the responses were overwhelmingly “most” or “all of the time” for positive relationship items and “very rarely” or “none of the time” for negative relationship items reflects the importance of romantic relationships for young adults. Its importance lies in the fact that a realistic evaluation of a romantic

relationship would in all likelihood contain a broader range of responses (i.e., more of a balance between positive and negative qualities) because all relationships, no matter how “healthy”, are imperfect and contain concerns and problems. The pattern of responses the young adults gave suggest that their relationships are surprisingly problem free. The reasons why young adults have imbued their relationships with such an unrealistic assessment are speculative but likely have to do with the importance of establishing successful intimate relationships. If having a successful relationship is paramount (Erikson, 1963), then perception of the relationship may be subject to a version of a *self-serving bias* - the tendency to perceive oneself favorably (Myers, 1993) - that is applied to the young adult’s relationship. This bias may occur because admission of problems may be indicative of failure in achieving an intimate relationship. The other possibility, concomitant with a self-serving bias, is that because young adult relationship experience is relatively limited (i.e., they have a small store of comparative experience) they may, in consequence, perceive these beginning relationships as wonderful and without difficulties.

The presence of this truncated variability limits the usefulness of the relationship satisfaction measure somewhat in the analysis and necessitates a degree of caution in the interpretation of the findings with this variable. The low variability may explain the absence of many predicted significant and substantial correlations between the relationship satisfaction measure and the other measures as well as its lack of significance as a predictor in suicidal behavior. Despite this qualification, the presence of some significant but small correlations between relationship satisfaction and depression over the week and year and family functioning eliminates the forgone conclusion that relationship satisfaction

is not related in some way to the other variables. The problems with variability in the measures of suicide were expected due to the relatively low frequency of the behavior. This problem was exacerbated for current suicidal behavior because there were so many reports of a complete absence of suicidal behavior over a two-week period. Unlike the relationship satisfaction measure, these distributions were seen as an accurate reflection of the phenomena of suicide. The presence of this difficulty with the suicide measures also necessitates some caution in the interpretation of findings and is particularly important with current suicidal behavior. Despite these important cautions for the measure of suicide, interesting and important findings were discovered with them.

Correlation Analysis

Many significant and substantial positive correlations between student's self reported ratings on depression, family functioning, relationship satisfaction and suicide were found. In general, the correlations indicate that there are several important interrelationships among these variables. In terms of suicidal behavior the findings indicate that increasing suicidal behavior is strongly associated with greater depression and increasingly problematic family functioning but not with relationship dissatisfaction. The absence of a significant correlation between relationship satisfaction and suicidal behavior may be due to the low variability in the relationship satisfaction measure. The reasons for this truncated variability have been discussed above. Other findings, discussed at length later, suggest that there is some relationship between suicidal ideation and attempts and difficulties in relationships. The strong relationship between depression and suicide is well

documented in suicidological literature and this was clearly demonstrated in this study. What was particularly informative was that the results indicate that more recent suicidal behavior (i.e., within the last two weeks) is associated with greater and more recent depressive symptoms. In contrast, a depression with a lengthier time span has a strong but relatively equal association with suicidal behavior both in the short term (i.e., within the last two weeks) and the long term (i.e., over the life time). Some caution in the interpretation of these relationships with suicide is required because as has been discussed the measures of suicide have a certain degree of skewness and kurtosis that may affect the nature of the relationship.

The findings for family functioning revealed that it was strongly related to depression, suicide and only marginally to relationship satisfaction. Poor family functioning was more strongly associated with depression over the year than over the week. This suggests that increasingly problematic family functioning is associated with greater depression in the long term as a young adult. This temporal difference was not found for suicide. While increasingly problematic family functioning was significantly related to young adult suicidal behavior, the association was not significantly different for suicidal behavior over the short and long term. This suggests that increasingly problematic family functioning is related to increased suicidal behavior in both the short and long term. This is in contrast to the pattern of the correlations of the family functioning subscales with suicidal behavior. That the correlations are significant but only marginal for suicide over the short term, but substantial for suicide over the long term, suggests that increasing problems in these dimensions of family functioning are related to a greater occurrence of

suicide in the long term as a young adult. A plausible explanation for this difference in findings may be that the dimensions individually have a greater effect in the long term, but when combined into the whole scale, potentially reveal the accrued influence of all these dimensions on suicidal behavior in the short term as well. The correlations between the family subscales and depression were similar to the pattern of correlations between the family subscales and suicide. The patterns of the correlations between depression, suicide and the family functioning subscales suggest that difficulties with Problem Solving, Communication, Affective Responsiveness, and Affective Involvement are important contributors to the depression and suicidal behavior of young adults in the long term. The Roles dimension was found to be significant and substantial in both in the short and long term for depression and suicide. Behavioral control was significant for depression and suicide but the relationships were marginal. This may be due to the fact that Behavioral Control was the least reliable subscale in the measure of family functioning. In sum these findings suggest that a family's capacity to resolve problems in ways that maintain integrity, and exchange information in clear and direct ways, provide resources, nurturance and support, and are emotionally responsive and interested are important components of family functioning. If problematic, these components are associated with depression and suicidal behavior in young adults.

The correlations of the relationship scale with the other measures were not as strong as the other inter-correlations. While many of the correlations were statistically significant they were not substantial. To reiterate, this may be due to the low variability observed in the response pattern in the relationship satisfaction measure. The non-

significant association between relationship satisfaction and suicide has been reviewed above. Relationship satisfaction was significantly correlated with depression over the short and long term but only the correlation over the short term was substantial. This may suggest that increasing relationship dissatisfaction is associated with greater depression in the short term. Relationship satisfaction was significantly but marginally correlated with family functioning as well as with many of the subscales. Interpretation of these relationships is difficult because of their marginal size. These findings may suggest that greater relationship dissatisfaction is associated with increasingly problematic family functioning especially in the areas of Problem Solving, Roles, Affective Responsiveness and Behavioral Control. All the interpretations regarding relationship satisfaction must be tempered because the low variability of the measure may minimize the correlation and not adequately reflect the size of relationship. While suggestive, many of the correlations lack strength and this necessitates caution in the interpretation of these relationships.

Hypothesis One: Difficulty Developing Intimacy & Suicidal Ideation and Attempt

It was predicted that, according to Erikson (1963), since the development of intimacy is important for young adults, difficulty in intimate relationships (as reflected in reporting it as the primary concern for contemplating suicide) would be related to suicidal ideation and attempts. This prediction was supported. It was found that those students reporting suicidal ideation at a mean age of 18 years indicated that boy or girl friend difficulties were the primary issue of concern that stimulated their suicidal thoughts. In contrast, those students who reported suicidal ideation around a mean age of 15 years

indicated that family difficulties were the primary concern. This finding suggests that the suicidal ideation of young adults is engendered more by difficulties in romantic relationships whereas the suicidal ideation of adolescents is stimulated more by difficulties in their families. For suicidal attempts similar results were observed. Students with a mean age of 17 indicated boy or girl friend difficulties as the primary concern while students with a mean age of 14 indicated family difficulties as the primary concern. The interpretation of attempters is not as clear because the age of the students reporting boy or girl friend difficulties is on the cusp of the young adulthood age range. This finding still supports the more general conclusion that older young persons indicate boy or girl friend difficulties as the primary issue of concern when attempting suicide. The decrease in mean age for attempts, in contrast to ideation, may be due to the fact that there are only 11 young adults reporting attempts and 25 young adults reporting attempts in adolescence which may depress the overall age of the sample.

These findings, regarding both types of suicidal behavior, lend support to Erikson's (1963) idea that the establishment of intimate relationships in young adulthood is an important need and the related idea that frustration of this need can lead to suicidal ideation and attempt. These findings are roughly consistent with findings of Meilman, Pattis & Zeilman (1984), Anda & Smith (1993), and Hawton, et. al. (1995a) which reported relationship difficulties as being a frequent concern for young adults. There are two qualifications that require mentioning. First it is important to note that the indication of boy or girl friend difficulties is a reflection of problems with intimacy and not a direct measure. Although the inference from boy/girl friend difficulties to problematic intimacy is

tenable, the finding can only be justifiably interpreted as strongly suggestive and not conclusive. Employment of the direct measure of intimacy (IMS) in this analysis was not possible due to its reduced variability and its effects are obvious in the other findings. It is also important to note that the sample of young adults reporting suicide attempts is quite small compared to the adolescent sample and there was an unequal number of women to men. This stands in contrast to ideation which had a greater number of young adults and approximately equal numbers of men and women. It is known from the suicidological literature that there tends to be a disproportional number of women who attempt and men who complete suicide. This raises an important question as to whether the finding of this hypothesis would be borne out for young adult, and particularly young adult male attempters, with a larger sample. The presence of a very small sample of young adult male attempters in this research prevented further analysis of these issues. The reasons why the sample of young adult attempters is small may have to do with the fact that nearly 90% of the young adults who attempted were serious (i.e. wanted to die and or required medical attention) which, if representative of young adult attempters, increases the probability of completion thereby reducing the number of young adults in the attempts category.

The findings regarding suicidal ideation and completion suggest that further confirmation of this hypothesis for young adult attempters is possible. The evidence that supports this is that the present findings on ideation and the research on completers (e.g., Leenaars, 1989a; 1989b; Hawton, et. al., 1995b) both indicate that relationship difficulties are a frequent and pressing concern and these represent either end of the continuum of suicidal behavior with attempts falling in between. One final important observation remains

to be mentioned. Although boy/girl friend difficulties were the primary or most serious concerns prompting suicidal ideation and attempt in young adults, they were not the only concerns. Students frequently reported other secondary or tertiary concerns that were related to their suicidal ideation and attempts. This suggests that, while there was a most serious concern, there may also be a perception of an accretion of additional problems (e.g., work, family, academic, friend difficulties) that may contribute to suicidal ideation and attempt in young adults. This is congruent with the findings of Meilman, Pattis & Zeilman (1984), Anda & Smith (1993), Hawton, et. al. (1995a) which reported that other difficulties were a significant, albeit a somewhat less frequent, reason for thinking about or attempting suicide.

Hypothesis Two: Familial Functioning & Intimate Relationships

It was hypothesized that problematic family relationships would be related to young adults' difficulties in intimate relationships. In brief it was found that those students reporting significant relationship difficulties (reflected in relationship dissatisfaction) also indicated more problematic family functioning. This finding is supported by a small but significant correlation between family functioning and relationship satisfaction suggesting that increasingly problematic family functioning is related to greater relationship dissatisfaction. In particular it was found that Problem Solving, Affective Responsiveness and Roles were the dimensions of family functioning that were significantly more problematic with reported relationship difficulties. To review these dimensions as defined by the measure, Problem Solving concerns to the capacity of the family to resolve

problems in ways that maintain effective family functioning and integrity. Affective Responsiveness is concerned with family members experience of appropriate affect in different situations (e.g., welfare, emergency). Roles focuses on the established patterns for handling family functions like the provision of nurturance, support and resources and the fairness and appropriateness of those patterns. In sum, these findings suggest that young adults reporting significant current relationship difficulties also indicate that the way their families remediated problems, were emotionally responsive and provided resources, nurturance and support was problematic in their experience.

This finding shares some consistency with the correlations between the family functioning subscales and relationship satisfaction. Problem Solving, Affective Responsiveness and Roles were also found to be significantly, although marginally, correlated with relationship satisfaction. It is not clear why the other dimensions of family functioning, Communication, Affective Involvement, Behavioral Control, and General Functioning, were not found to be more problematic with reported relationship problems. For Communication and Affective Involvement the lack of a finding is supported by the absence of a significant correlation with relationship satisfaction. Although Behavioral Control had a marginal but significant relationship with relationship satisfaction it was the least reliable subscale which may explain its absence. For General Functioning there is no clear explanation despite its significant but marginal correlation with relationship satisfaction. There are several other explanatory possibilities. One is that these family dimensions may have not been notably problematic. Another possibility is that they, as measured, may have been less relevant in the relationship between family functioning and

later relationship difficulties. A final possibility is that the low variability of the relationship satisfaction measure may have obscured the relevance of these other dimensions of family functioning.

The findings of this hypothesis are important because they extend the research findings concerning the relevance of family functioning in adolescents to young adults and identify a connection between problematic family functioning and difficulties with intimacy. The adolescent research characterized problematic family relationships as less cohesive, involving and supportive and more conflictual, aversive and controlling. These qualities were also found to have negative effects on adolescents' social competence, self-esteem, problem solving and communication skills, and involvement with others. These family problems identified in adolescents share a fair degree of similarity with the dimensions of family functioning, if problematic, in this current research on young adults. The present research extends these adolescent findings in that similar difficulties were found salient for young adults. A preliminary conclusion that can be drawn from this is that problematic family functioning, or at least the effects, can remain salient for young adults.

In terms of intimacy, a few research studies (e.g., Rudd, 1989, 1990; de-Anda & Smith 1993; Goldney, 1981) investigating suicidal ideation and attempts in young adults note the importance of problematic family relationships but they did not clarify a connection between it and difficulties with intimacy. This present research has identified a connection between problematic family functioning and relationship difficulty in young adults. It is possible to speculate how these three dimensions in family functioning,

Problem Solving, Affective Responsiveness, and Roles, if problematic, might interfere with a young adults later success in establishing intimate romantic relationships. The essence of these three dimensions concern the psychosocial welfare and support of individuals in the family. These three qualities are arguably necessities for establishing and maintaining a successful intimate relationship. If difficulties in these three areas were experienced growing up and they remain salient as suggested by this research, then it is possible that the ability to negotiate intimate relationships employing the skills gleaned from these three dimensions would be distorted and limited. This may interfere with the young adult's attempts to establish relationships. The consequence would be limitations in a young adult's resources for effective problem resolution, his or her experiential knowledge of how to be appropriately emotionally responsive and sense of how to provide support and resources.

Hypothesis Three: The Prediction of Suicidal Behavior From Family Functioning.

Relationship Satisfaction and Depression

It was hypothesized that difficulty in intimate relationships, problematic family functioning and depression would be related and contribute to the prediction of suicidal behavior in young adults. It was found that current depression and family functioning but not relationship satisfaction were significant predictors of suicidal behavior within the last two weeks. Relationship satisfaction was not significant despite the fact that it was significantly correlated with the measure of suicide. This may be due to the fact that the correlation was relatively small and its strength may have been ultimately diminished by

the truncated variability in the relationship measure. For suicidal behavior over the lifetime it was similarly found that depression over the past year and family functioning but not relationship satisfaction predicted suicidal behavior over the life time. In this case relationship satisfaction was not significantly correlated with the measure of suicide. This is consistent with the Pearson correlations which indicated that the measure of suicide unexpectedly did not have a significant association with relationship satisfaction. The significance of depression and family functioning as predictors is also consistent with the Pearson correlations which indicate significant relationships between depression, family functioning and suicide. The findings from the regression and Pearson correlations may interconnect and open up the speculative possibility of a more complex relationship among relationship satisfaction, depression and suicide. The Pearson correlation between relationship satisfaction and depression suggest that increasing relationship dissatisfaction is associated with greater depression in the short term. This has implication for suicidal behavior in that depression is the strongest predictor of suicidal behavior and, from the Pearson correlations, greater and more recent depression is correlated with increasing and more recent suicidal behavior.

To return to the main findings, in both of these analyses, depression and family functioning, together proved to be strong predictors of suicide accounting for a relatively large amount of the variance. In both cases depression was found to be the strongest predictor by far while family functioning followed in strength. Examining the Standardized Regression Coefficients in terms of predictive strength for current suicidal behavior, depression over the last week accounts for slightly more than twice that of family

functioning. With suicidal behavior over the lifetime, depression over the year accounts for over five times that of family functioning. These findings are consistent with the general trends in the suicidological literature which indicates that depression is overwhelmingly the strongest predictor. This does not minimize the importance of finding family functioning as a relevant variable which contributes significantly and independently to the prediction of suicidal behavior in young adults. What is not clear is why family functioning appears to lose some of its predictive power for suicidal behavior over time and what role does family functioning play in the suicidal behavior of young adults.

These findings are important because they extend the conclusions of the adolescent research (e.g., Adams, Overholser, & Lehnert, 1994; Brent, et. al 1994) and follow the findings of Rudd (1989, 1990), de Anda & Smith (1993) and Hawton, et. al. (1995a) to confirm the existence of an important relationship between the suicidal behavior of young adults and family difficulties. These findings are also consistent with the findings of the second hypothesis and together they suggest that family functioning remains a significant influence upon the lives of young adults. It is notable that, unlike some of the adolescent research, this study determined that family functioning contributed to suicidal behavior without depression having to be statistically controlled. In addition, in contrast to the past young adult studies reviewed, this present study applied a regression analysis to these variables to examine their importance in the relationship. In the past young adult research cited the investigations were predominantly limited to a frequencies-based analysis. Finally to speculate upon the role of family functioning in the suicidal behavior of young adults the findings of the first and third hypothesis must be examined together. The first

hypothesis suggests that unlike adolescents, family difficulties do not seem to be a predominant concern when considering or attempting suicide. In contrast, concerning the findings of the third hypothesis family functioning was found to be a significant but secondary predictor. These two findings suggest that the influence of family functioning may be subtle and indirect. For young adults their familial experiences may be somewhat antecedent to their current situation in which suicide is considered but the negative effects may remain in the background and exert an exacerbating influence in the current situation.

That relationship satisfaction was not found to be a significant predictor stands in contrast to the finding of the first hypothesis which found that young adults frequently indicated boy or girl friend difficulties as the primary reason for thinking about or attempting suicide. This also stands in contrast to the young adult suicide research reviewed that similarly found that various relationship issues were frequently connected with suicidal behavior. Again, as already has been discussed, this may be due to the truncated variability in the measure of relationship satisfaction stemming from young adults' idealized reports of their relationships. Another important point is that in the young adult research previously reviewed there were no attempts to measure the nature of young adult relationships beyond a simple categorical indication of difficulties or their absence. A categorical method was employed in the first hypothesis of this study and it was found that young adults report relationship difficulties when thinking about or attempting suicide. How can this apparent contradiction be explained? What this suggests is that in the absence of any immediately presenting problems, young adults view their relationships as idealized and free of problems. When young adults encounter inevitable difficulties in the

relationship, they can be traumatic experiences given the idealized view and the importance of establishing relationships, and this may increase the young adults vulnerability to suicidal behavior. This tendency to idealize presents a particular problem for future research in terms of how to measure young adult relationships accurately. Consistent with the findings of the first hypothesis it appears that the difficulties in or dissolution of relationships is the point where suicidal behavior becomes a concern and this is where future investigation might focus.

Conclusions, Limitations, Future Research & Clinical Relevance

The goal of this research was to determine the developmental and familial factors that are related to suicidal ideation and attempts in young adults. Although questions remain and limitations exist this investigation in sum found and examined these factors that were related to suicidal behavior. Theoretically it was argued that psychologically an important developmental issue facing young adults is the development of intimate interpersonal relationships. The problematic establishment of intimacy risks social and emotional isolation. Since intimacy is necessarily relational in nature, the patterns of intimacy exposed to while growing up may have a significant impact in establishing intimacy with others. The family provided one of the most crucial patterns of intimate interpersonal relating to which individuals were exposed. If patterns of familial intimacy were problematic then the young adult might later encounter difficulty in developing and maintaining intimate relationships with others. Given the importance of establishing intimate relationships for young adults, difficulty with this developmental goal, if serious

enough, may result in distress, depression, and suicidal ideation and attempt.

It was observed that demographically a range of suicidal ideation and attempt is a frequent and disturbing problem for young adults. There are three major findings from this study. First, young adults tended to indicate relationship difficulties as the most serious concern when considering or attempting suicide. This was in contrast to adolescents who tended indicate family difficulties as the most serious concern. This finding provides support for Erikson's theory that in young adulthood the establishment of intimate relationships is salient and that frustration of this developmental goal is connected to suicidal behavior. Second, young adults who reported significant relationship difficulties also indicated more problematic family functioning. This finding was augmented by the finding that Problem Solving, Affective Responsiveness, and Roles were the dimensions of family functioning that were significantly more problematic with reported relationship difficulties. Thirdly, depression and family functioning but not relationship satisfaction were significant predictors of suicidal behavior in the short and long term. Depression was the strongest predictor followed by family functioning. In general the Pearson correlations among the variables provide support for the major findings and were consistent with the unexpected findings in this study.

Many of the specific limitations and concerns have already been discussed with respect to the relevant findings but a pervasive one bears reviewing again. The most notable limitation is the presence of truncated variability in the relationship and suicide measures. Although these were the empirical distributions created by an idealized view of romantic relationships and the relatively low frequency of suicidal behavior, they

necessitate a degree of caution in the interpretation of findings involving these variables. In terms of relationship satisfaction, young adults reported that they were overwhelmingly satisfied with their relationships. In consequence it is not surprising that small or non-existent relationships were found with many of the variables. Nonetheless, the presence of some findings are suggestive that relationship satisfaction is connected to the other variables in some way. The measures of suicide also demonstrated problems in their distributions which suggest some caution in interpretation of relationships involving these measures. Despite this difficulty, the relationships among suicide and many of the other variables appeared significant and strong which underscores the strength of these relationships.

This study, like all complex research, while answering some specific questions, stimulated related questions that remain to be answered. While several questions were raised in this research three important ones will be mentioned. The first would be to devise a way to measure young adult relationships accurately given their observed tendency to idealize their relationships. One possible solution would be to measure young adults perception of their relationship when they are currently having difficulties. It is possible that this might provide a more realistic picture of the quality of the relationship and its association with other variables. If the young adults were experiencing some related distress or depression this approach may work theoretically using the effects of the *depressive realism* phenomenon- the tendency for mildly depressed individuals to make more accurate judgments about themselves and their situation (Myers, 1993). Of course the possibility of finding reports of overwhelming dissatisfaction under this condition is a

potential limitation of this solution. Nonetheless this may help to clarify the role that intimacy is suggested to play in young adult suicide. A second area of research would be to follow up with young adult attempters, particularly males, to procure a larger sample to investigate whether problems in establishing and maintaining intimate relationships is a significant concern for them. This is a valuable area to follow up on in that the relatively small sample in this study prevented further analysis and consequently the findings are not conclusive. Finally, a third possibility for future study might be to clarify the role family functioning, particularly the dimensions identified, plays in the suicidal behavior of young adults. This question was addressed in part in this present research but follow up investigation may help to delineate the functional nature of these dimensions and their potentially complex relationship with young adult relationships and suicidal behavior.

The clinical relevance or contribution of the findings of this study is that they help to understand some of the relationships among a salient developmental issue of young adults, problematic family relationships and suicidal behavior. This understanding has some practical implications for intervention processes and augmenting prevention strategies. This study suggests that, suicidal behavior, family functioning, relationship difficulty, and depression, are connected and this knowledge provides a constellation of interrelated difficulties relevant for young adults. The areas in this constellation could potentially be considered general risk factors that may be important to examine when dealing with young adults in distress and particularly when evaluating risk for suicide. This knowledge may help the clinician to understand the situation of a young adult and intervene effectively. In addition inclusion of this constellation of interrelated difficulties in

suicide prevention programs may augment the strategies designed to educate about and prevent suicide particularly in places where young adults are populous.

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Enterprises

APPENDICES

APPENDIX A

**CENTER FOR EPIDEMIOLOGICAL STUDIES DEPRESSED MOOD SCALE
(CES-D)**

Using the scale below indicate the number which best describes how often you felt or behaved this way during the past week.

- 0 = Rarely or none of the time (less than one day)
1 = Some or a little of the time (1-2 days)
2 = Occasionally or a moderate amount of time (3-4 days)
3 = Most of the time (5-7 days)

DURING THE PAST WEEK

1. _____ I was bothered by things that usually don't bother me.
2. _____ I did not feel like eating; my appetite was poor.
3. _____ I felt that I could not shake off the blues even with help from my family or friends.
4. _____ I felt I was just as good as other people.
5. _____ I had trouble keeping my mind on what I was doing.
6. _____ I felt depressed.
7. _____ I felt that everything I did was an effort.
8. _____ I felt hopeful about the future.
9. _____ I thought my life had been a failure.
10. _____ I felt fearful.
11. _____ My sleep was restless.
12. _____ I was happy.
13. _____ I talked less than usual.
14. _____ I felt lonely.
15. _____ People were unfriendly.
16. _____ I enjoyed my Life.
17. _____ I had crying spells.
18. _____ I felt sad.
19. _____ I felt that people disliked me.
20. _____ I could not get going.

DURING THE PAST YEAR

0 = Rarely or none of the time

1 = Some or a little of the time

2 = Occasionally or a moderate amount of time

3 = Most of the time

1. _____ I was bothered by things that usually don't bother me.
2. _____ I did not feel like eating; my appetite was poor.
3. _____ I felt that I could not shake off the blues even with help from my family or friends.
4. _____ I felt I was just as good as other people.
5. _____ I had trouble keeping my mind on what I was doing.
6. _____ I felt depressed.
7. _____ I felt that everything I did was an effort.
8. _____ I felt hopeful about the future.
9. _____ I thought my life had been a failure.
10. _____ I felt fearful.
11. _____ My sleep was restless.
12. _____ I was happy.
13. _____ I talked less than usual.
14. _____ I felt lonely.
15. _____ People were unfriendly.
16. _____ I enjoyed my Life.
17. _____ I had crying spells.
18. _____ I felt sad.
19. _____ I felt that people disliked me.
20. _____ I could not get going.

APPENDIX B

HARKAVY ASNIS SUICIDE SURVEY (HASS)**PART 1**

Please circle the number that fits best. These questions pertain to the **PAST 2 WEEKS**.
Please answer all the questions. Thank you for your cooperation.

- 0 = Never
- 1 = Once
- 2 = 1-2 times per week
- 3 = 3-4 times per week
- 4 = Daily

HOW OFTEN HAVE YOU:

1. ____ Thought that you would be better off dead?
2. ____ Dreamed about death?
3. ____ Had ideas about killing yourself?
4. ____ Thought the world would be better of without you?
5. ____ Thought about death and dying?
6. ____ Smoked marijuana?
7. ____ Been in high places and felt like jumping?
8. ____ Thought about ways to kill yourself
9. ____ Taken drugs other than marijuana or prescription drugs?
10. ____ Become so discouraged that you thought about ending your life?
11. ____ Felt like running into traffic?
12. ____ Had a plan of how you would kill yourself?
13. ____ Wished you were dead?
14. ____ Felt that life was not worth living?
15. ____ Drunk alcoholic beverages?
16. ____ Thought about killing yourself but did not try to do it?
17. ____ Tried to kill yourself?
18. ____ Dreamed about killing yourself?
19. ____ Talked to someone about killing yourself?
20. ____ Had a plan to kill yourself to do it and then stopped at the last minute?
21. ____ Smoked cigarettes?
22. ____ Intended to die when you tired to kill yourself?
23. ____ Been under the influence of alcohol when you tired to kill yourself?

PART 2

Please circle the number that fits best. These questions pertain to your whole LIFE except for the last 2 weeks. Please answer all the questions.

- 0 = Never
- 1 = Once
- 2 = 2-3 times
- 3 = 4-5 times
- 4 = 6+ times

HOW OFTEN HAVE YOU:

1. ____ Thought that you would be better off dead?
2. ____ Dreamed about death?
3. ____ Had ideas about killing yourself?
4. ____ Thought the world would be better off without you?
5. ____ Thought about death and dying?
6. ____ Smoked marijuana?
7. ____ Been in high places and felt like jumping?
8. ____ Thought about ways to kill yourself
9. ____ Taken drugs other than marijuana or prescription drugs?
10. ____ Become so discouraged that you thought about ending your life?
11. ____ Felt like running into traffic?
12. ____ Had a plan of how you would kill yourself?
13. ____ Wished you were dead?
14. ____ Felt that life was not worth living?
15. ____ Drunk alcoholic beverages?
16. ____ Thought about killing yourself but did not try to do it?
17. ____ Tried to kill yourself?
18. ____ Dreamed about killing yourself?
19. ____ Talked to someone about killing yourself?
20. ____ Had a plan to kill yourself to do it and then stopped at the last minute?
21. ____ Smoked cigarettes?
22. ____ Intended to die when you tried to kill yourself?
23. ____ Been under the influence of alcohol when you tried to kill yourself?

PART 3

1. Have you ever thought about killing yourself but did not actually try? Y [] N []
 A. (If yes) Have those thoughts persisted for at least 7 days in a row? Y [] N []
 B. How old were you when you had these thoughts? _____
 C. Did you have a plan? Y [] N []
 D. How come you were thinking of suicide? Please check as many as apply. If more than ONE applies please rank most serious concern #1, the second #2 and so on.

Girl/Boyfriend difficulties [], Academic difficulties [], Family difficulties [],
 Friend difficulties [], Work difficulties [],
 Other difficulties (please specify below) _____

2. Have you ever thought about killing yourself in the past week?
 A. (If yes) Have these thoughts persisted for 7 days in a row? Y [] N []
 B. Do you have a plan? Y [] N []
3. Have you ever tried to kill your self? Y [] N []
 A. How many times?
 B. At what age (s)?
 C. How many times prior to age 18? _____. How many times after age 18? _____.
 D. How specifically did you try to kill yourself (please specify)? _____
 E. How come you tried to kill yourself Please check as many as apply. If more than ONE applies please rank most serious concern #1, the second #2 and so on.

Girl/Boyfriend difficulties [], Academic difficulties [], Family difficulties [],
 Friend difficulties [], Work difficulties [],
 Other difficulties (please specify below) _____

- F. Did you require medical treatment after you tried to kill yourself? Y [] N []
 G. Did you tell anyone before? after?
 H. Did you want to die? Y [] N []
 I. Did you expect to die? Y [] N []
 J. When you attempted suicide were you under the influence of alcohol, prescription medication and/or non- prescription medication? (Not the method) Y [] N []

- K. Were you in psychiatric treatment when you tried? Y [] N []
 L. Did you start psychiatric treatment within the month after you tried to kill yourself? Y [] N []

4. Have family members talked about killing themselves? Y [] N []
 If yes who (relationship)?
 5. Has anyone in your family tried to kill him/herself? Y [] N []
 If yes who (relationship)?
 6. Did you know anyone who has tried to kill themselves? Y [] N []
 If yes who (relationship)?
 7. Did you know anybody who has killed themselves? Y [] N []
 If yes who (relationship)?
 8. Have you ever seen a professional for any emotional problems you were having at the time of thinking about or attempting suicide? Y [] N []. Are you in treatment now? Y [] N [].
 Type: Psychologist [] Psychiatrist [] Social Worker [] Counselor []
 Religious leader []

APPENDIX C

INDEX OF ROMANTIC RELATIONSHIP SATISFACTION

This questionnaire is designed to measure the degree of satisfaction you have with your present romantic relationship with a significant partner. This applies to married couples, boy or girl friends as well as heterosexual and homosexual relationships. If you are not in a romantic relationship currently please rate your satisfaction to the closest friend you have. Please indicate the type of relationship: Romantic [] Friend []. Please indicate length of relationship _____. This is not a test so there are no wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

- 1 = None of the time
- 2 = Very rarely
- 3 = A little of the time
- 4 = Some of the time
- 5 = A good part of the time
- 6 = Most of the time
- 7 = All of the time

1. _____ My partner really cares for me.
2. _____ My partner treats me badly.
3. _____ I feel that I would not chose the same partner if I had it to do over again.
4. _____ I feel I can trust my partner.
5. _____ I feel that our relationship is breaking up.
6. _____ My partner really doesn't understand me.
7. _____ I feel that our relationship is a good one.
8. _____ Ours is a very happy relationship.
9. _____ Our time together is dull.
10. _____ We have a lot of fun together.
11. _____ My partner does not confide in me.
12. _____ Ours is a very close relationship.
13. _____ I feel that I cannot rely on my partner.
14. _____ I feel that we do not have enough interests in common.
15. _____ We manage arguments and disagreements very well.
16. _____ My partner is affectionate enough.
17. _____ I feel that I should have never got involved with my partner.
18. _____ My partner and I get along very well together.
19. _____ Our relationship is very stable.
20. _____ My partner is a real comfort to me.

21. _____ I feel that I no longer care for my partner.
22. _____ I feel that the future looks bright for our relationship.
23. _____ I feel that our relationship is empty.
24. _____ I feel that there is no excitement in our relationship.
25. _____ I feel that I can discuss anything with my partner.

26. How close are you with this person in your current relationship (rate from 1-5 below):
_____.

1= not at all close
2= somewhat close
3= quite close

4= very close
5= closest I have ever been

APPENDIX D

FAMILY ASSESSMENT DEVICE

The following pages contain a number of statements about families. Please read each statement carefully and decide how well it describes your own family. You should answer to how you see your family.

For each statement there are 4 possible responses:

- 1 = Strongly Agree (Select if you feel that the statement describes your family very accurately)
- 2 = Agree (Select if you feel that the statement describes your family for the most part)
- 3 = Disagree (Select if you feel that the statement does not describe your family for the most part)
- 4 = Strongly Disagree (Select if you feel that the statement does not describe your family at all)

1. ____ Planning family activities is difficult because we misunderstand each other.
2. ____ We resolve most everyday problems around the house.
3. ____ When someone is upset the others know why.
4. ____ When you ask someone to do something you have to check that they did it.
5. ____ If someone is in trouble the others become too involved.
6. ____ In times of crisis we can turn to each other for support.
7. ____ We don't know what to do when an emergency comes up.
8. ____ We sometimes run out of things we need.
9. ____ We are reluctant to show our affection for each other.
10. ____ We make sure members meet their family responsibilities.
11. ____ We cannot talk to each other about the sadness we feel.
12. ____ We usually act on our decisions regarding problems.
13. ____ You only get the interest of others when something is important to them.
14. ____ You can't tell how a person is feeling from what they are saying.
15. ____ Family tasks don't get spread around enough.
16. ____ Individuals are accepted for what they are.
17. ____ You can easily get away with breaking the rules.
18. ____ People come right out and say things instead of hinting at them.
19. ____ Some of us just don't respond emotionally.
20. ____ We know what to do in an emergency.
21. ____ We avoid discussing our fears and concerns.
22. ____ It is difficult to talk to each other about tender feelings.
23. ____ We have trouble meeting our bills.
24. ____ After our family tries to solve a problem, we usually discuss whether it worked

or not.

25. _____ We are too self centered.
26. _____ We can express feelings to each other.
27. _____ We have no clear expectations about appropriate family behavior.
28. _____ We do not show our love for each other.
29. _____ We talk to people directly rather than through go betweens.
30. _____ Each of us has particular duties and responsibilities.
31. _____ There are lots of bad feelings in the family.
32. _____ We have rules about hitting people.
33. _____ We got involved with each other only when something interests us.
34. _____ There is little time to explore personal interests.
35. _____ We often don't say what we mean.
36. _____ We feel accepted for what we are.
37. _____ We show interest in each other when we can get something out of it personally.
38. _____ We resolve most emotional upsets that come up.
39. _____ Tenderness takes second place to other things in our family.
40. _____ We discuss who is to do household jobs.
41. _____ Making decisions is a problem for our family.
42. _____ Our family only shows interest in each other only when they can get something out of it.
43. _____ We are frank with each other.
44. _____ We don't hold to any rules or standards.
45. _____ If people are asked to do something, they need reminding.
46. _____ We are able to make decisions about how to solve problems.
47. _____ If the rules are broken, we don't know what to expect.
48. _____ Anything goes in our family.
49. _____ We express tenderness.
50. _____ We confront problems involving feelings.
51. _____ We don't get along well together.
52. _____ We don't talk to each other when we are angry.
53. _____ We are generally dissatisfied with the family duties assigned to us.
54. _____ Even though we mean well, we intrude too much into each others lives.
55. _____ There are rules about dangerous situations.
56. _____ We confide in each other.
57. _____ We cry openly.
58. _____ We don't have reasonable transport.
59. _____ When we don't like what someone has done, we tell them.
60. _____ We try to think of different ways to solve problems.

APPENDIX E

DEMOGRAPHIC INFORMATION

1. Age _____
2. Sex _____
3. Race _____
4. Major _____
5. Year of Study _____
6. Religion _____
7. Living Arrangement: Alone [☐] Roommate(s) [☐] Partner [☐] Family [☐]
Relative [☐] Other _____
8. Marital Status: Single [☐] Married [☐] Divorced [☐] Separated [☐]
Common Law [☐] Other _____
9. Are you in a relationship with a significant other presently? Y [☐] N [☐]
10. How long have you been in your current relationship? [] Not/Applicable
[]
11. If you are not presently in a relationship is it an important concern you? Y [☐] N [☐]
12. If you are not presently in a relationship would you like to be in one in the near future?
Y [☐] N [☐]
13. How many relationships have you been in since you were 18? []
Average length? []
14. How would you describe your past relationships in general (circle one)?
Good Bad Mediocre Not/Applicable
15. How would you describe your present relationship in general (circle one)?
Good Bad Mediocre Not/Applicable

APPENDIX F

CONSENT FORM

I _____ (please print) hereby understand and consent to the following:

I am being asked to complete a series of questions concerning my experience with relationships with others, with my family, with suicidal behavior and with depression. Although many of the questions are of a general nature, many of them ask about issues that may be upsetting to some people. The purpose of this study is to learn about the relationship among these areas.

I understand that participation in this study will not involve any known harm or deception. I am aware that my participation is completely voluntary. I have the right to withdraw from participation at any time without explanation or penalty. I may also refrain from answering any questions I prefer to omit. I may ask questions during my participation. Michael Oosterhoff (Graduate student) or Dr. Bill Balance (Supervisor) can be contacted at 253-4232 ext. 2227 for any further questions, comments or discussion. Information sheets summarizing the results will be posted in the University of Windsor psychology department once the data collection and analysis are complete. These information sheets will be likely be available in August/September 1998.

I Understand that my responses will be kept strictly confidential. Confidentiality regarding my responses will be protected by: 1. Not having my name or any other identifying information appear on the questionnaires; 2. My own individual responses will not be available in the aggregate results; and 3. My identity or that of other participants will not be made known. The results of this study may be published or presented at a later date and strict confidentiality will remain protected.

I am being asked to participate on one occasion to complete this study. I will receive course credit for my participation.

This procedure had been cleared by the Ethics Committee of the Psychology Department, University of Windsor. Concerns can be directed to the Ethics Committee Chairs, Sylvia Voelker and Doug Shore at 253-4232 ext. 2249 and 2253. I have received a copy of this consent form and a list of community resources for crises. The copy of the consent form that I submit to the researcher will be kept separate from my questionnaire.

I understand this information and voluntarily consent to participate in this study.

Signature

Date

Thank you for your participation.

APPENDIX G

DEBRIEFING FORM

The purpose of this research is to investigate the extent to which the suicidal thoughts and attempts of young adults (18-25 years old) are related to difficulties in establishing romantic intimacy, dysfunctional family relationships and depression. It is expected that these areas should be interrelated and that increasing difficulty in the establishment of intimacy should correspond to more serious suicidal behavior, increasingly problematic family relationships and greater depression. The theoretical rationale for this research follows below.

Psychologically an important developmental issue that faces young adults is the development of intimacy in interpersonal relationships. This involves the establishment and maintenance of enduring romantic affiliations with partners that are mutually intimate, committed and supportive. Since the establishment of intimacy is necessarily relational in nature the patterns of intimate relating exposed to while growing up likely have a significant impact on the success in establishing intimacy with others. One of the most salient patterns of intimate interpersonal relating that an individual was exposed to while growing up was within the family. If patterns of familial intimacy that a young adult was exposed to were dysfunctional (e.g., contained abuse, were excessively critical) then it is likely that the young adult might have difficulty in developing and maintaining intimacy on his or her own. This difficulty, if serious enough, may consequently lead to distress, depression and suicidal behavior.

COMMUNITY RESOURCES

PSYCHOLOGICAL SERVICES

253-4232 ext.
7012

(for all students)

WINDSOR DISTRESS CENTER

(all crises)

256-5000

VITA AUCTORIS

Michael E. A. Oosterhoff completed an Interdisciplinary Bachelor of Arts degree in 1993 and subsequently completed a Bachelor of Arts degree in Psychology in 1996 at the University of Western Ontario. Since 1996, Michael Oosterhoff has been enrolled in the doctoral program in Adult Clinical Psychology at the University of Windsor. He is currently a candidate for the Masters Degree in Clinical Psychology from the University of Windsor.